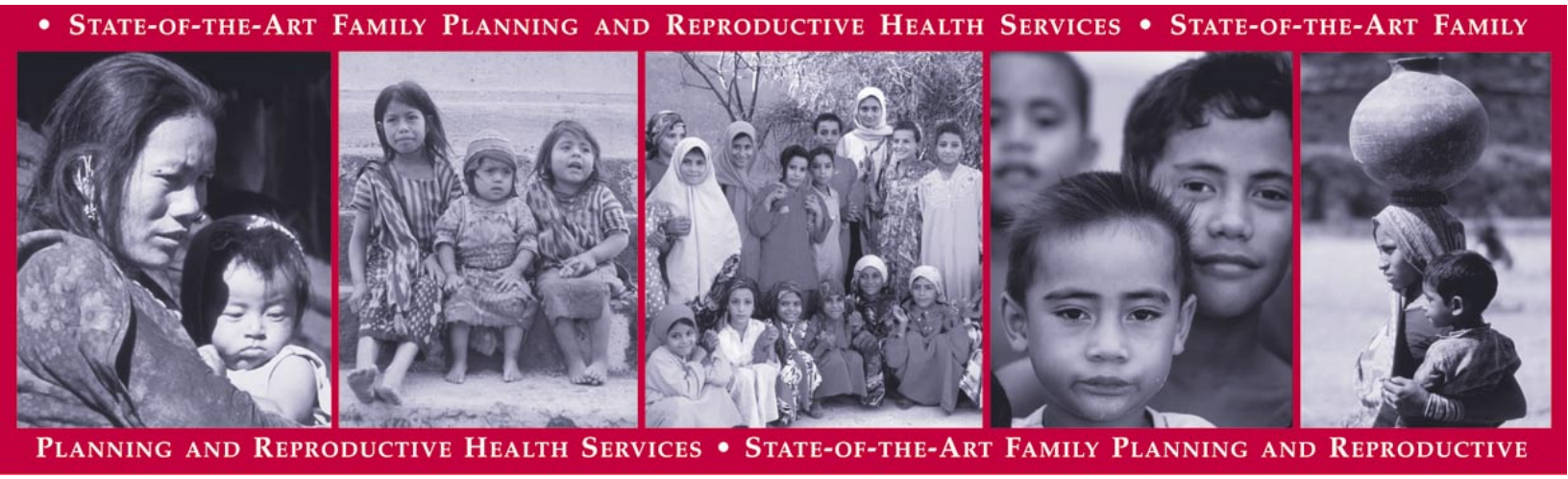

Egyptian Focus Groups on Birth Spacing

Qualitative Study in Egypt

2003

CATALYST
consortium

EGYPTIAN FOCUS GROUPS ON BIRTH SPACING

Qualitative Study in Egypt

(One in a series of five country studies, including Bolivia, India, Pakistan and Peru)

2003

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I. INTRODUCTION

The Optimal Birth Spacing Initiative (OBSI) is an activity of the CATALYST Consortium designed to place optimal birth spacing on the global public health agenda by instituting a recommendation for three to five year birth intervals at the policy, programmatic and behavioral levels. The objectives of OBSI are: (1) to create consensus among international organizations and program managers on the strong association between birth intervals of three to five years and improved maternal and child health outcomes; (2) to strengthen health services, provider training and community programs with birth spacing programming; and (3) to empower individuals and families to adopt birth spacing behaviors. To collaborate on the Initiative, CATALYST has gathered a group of Birth Spacing Champions as an ongoing working group, including over 30 representatives from USAID, UNICEF, and interested cooperating agencies (CAs), non-governmental organizations (NGOs), academics and researchers.

CATALYST has collected and commissioned quantitative research on the health impact of optimal birth spacing. This research shows that when births are spaced three to five years apart there are substantially more health benefits for neonates, infants, children and mothers than the previously recommended two-year birth spacing interval. Research findings from North America, Asia, the Middle East/North Africa, Latin America/Caribbean and Sub-Saharan Africa have shown the following:

- Short birth intervals are a key risk factor for maternal and perinatal morbidity and mortality. This effect remains when the data are statistically controlled for socio-demographic and biological variables. (Conde-Agudelo and Belizan, 2000; Fuentes-Afflick et al., 2002; Zhu et al., 1999; Zhu et al., 2001)

- The lowest perinatal mortality occurs with a 36-47 month birth interval and the fewest miscarriages occur with 24-35 month birth intervals. (Rutstein, 2002)

- Women with birth intervals of less than 15 months, have 2.54 times the risk of maternal death compared to women with birth intervals of 27-32 months. Women with long birth intervals (>69 months) have a higher risk for adverse maternal outcomes such as preeclampsia and eclampsia. (Conde-Agudelo and Belizan, 2000)

- In Latin America adolescents aged 15-19 comprise 80% of the group with the shortest birth intervals. Adolescents who are 16 years of age are four times more likely to die of pregnancy-related causes compared to mothers aged 20-24 years. Infants of these mothers face an increased risk for low birth weight, small for gestational age and preterm delivery. (Conde-Agudelo, 2002)

- There is a substantial demand for birth spacing among young and low-parity women, and a demand among zero-parity women to delay their first births. (Jansen et al., 2002)

As part of the OBSI strategy, CATALYST has commissioned qualitative research in order to better understand the many and complex issues that shape reproductive health and spacing behaviors. Focus group studies were conducted in five countries – Bolivia, Peru, India, Pakistan and Egypt. Reports from each country will be available on the CATALYST website with an additional cross-countries analysis to determine commonalities. Findings from the focus groups will provide the foundation for developing optimal birth spacing guidance, counseling materials, and training guidelines and will also foster collaboration between the public, private and NGO sectors.

II. STUDY OBJECTIVES

The overall purpose of this study was to provide information to better assist in improving the health of women and children through optimal birth spacing by providing greater understanding through collection and analysis of specific information on:

- The knowledge, attitudes and practices of married women with regard to birth spacing;
- The role of husbands and mothers-in-law in decision-making regarding birth spacing; and
- Opinions and views of family planning and reproductive health service providers.

III. RESEARCH METHODOLOGY

The latest EDHS (El-Zanaty & Way, 2001) indicate that Egyptian women begin having children early in their reproductive period. The average Egyptian woman gives birth to two-thirds of the births she will have in her lifetime by the age of 30. Rural women, especially in Upper Egypt, have the highest birth rates among women aged 15-19 years and the highest total fertility rate of 4.7 children, as compared to 3.3 children for women in rural Lower Egypt and 3.5 children for the national average. Although the average birth interval is relatively high in Egypt (median=34 months) this interval varies widely by age group. More than half of the women aged 15-19 and about one-third of the women between ages 20 and 29 have birth intervals of less than 24 months. Also, birth intervals tend to be shorter in Upper Egypt compared to Lower Egypt and urban governorates (median=32.4 months vs. 35.4 and 38.2, respectively).

Additionally, EDHS data demonstrate that the reproductive goals of many married women are not met with appropriate contraceptive use. For married women aged 15-19 years, 50.4% would like to have another child, but would like to practice spacing, and 6.6% want no more children, but only 22% of these women practice family planning. The same holds true for age groups 20-24 and 25-29 years in which those who want to postpone pregnancy and those who do not want any more children are greater than the percentage actually using modern contraceptives.

Thus it is important to understand the knowledge, attitudes and practices of women, particularly young mothers, and those who have influence over them with regard to birth spacing. Results of this study will provide policy makers in Egypt with information to help them design successful interventions to achieve optimal birth spacing and hence improve the health of women and children in Egypt.

The Population Report from the summer of 2002 provides evidence that birth intervals longer than two years are better for the health and survival of mothers and infants (Population Reports, Series L, Number 13, 2002). Research findings have indicated that children born three to five years after a previous birth are about two and a half times more likely to survive than children born before two years. Mothers also are two and a half times more likely to survive childbirth if they have 27-32 month births intervals as compared to those who have birth intervals of 9-14 months. Women are also more likely to avoid anemia and third trimester bleeding, and less likely to experience fetal growth retardation and premature delivery that can result in low birth weight. However, the knowledge and attitudes of the Egyptian public and healthcare providers in relation to birth spacing have until now not been studied.

This investigation was conceived as a qualitative study using a focus group discussion methodology and was implemented in three governorates in Egypt. Two peri-urban locations from Cairo (Matariya and Manshiet Nasser) and one urban and one rural location in each of the Governorates of Minia and Sohag from Upper Egypt were selected.

The study was facilitated by five moderators who solicited information on the knowledge, attitudes and practices of married women who practice spacing and those who do not, as well as husbands, mothers-in-law and family planning and reproductive health service providers who are physicians and nurses. Married women spacers and nonspacers were divided into two age groups, one of women aged 15-22 years and the other for women aged 23-35 years. Husbands were divided into the husbands of young women in the first age bracket and the husbands of older women in the second age bracket.

Married women spacers were defined as: (1) women who have children that are spaced at least 24 months apart, as measured from the birth of one child to the birth of the next child; (2) women whose youngest child is at least two years old but who still want more children; or (3) women whose last child is less than 15 months old, but who are currently using a contraceptive method with the purpose of delaying pregnancy.

Nonspacers were defined as: (1) women who have a birth interval between two deliveries of less than 24 months; (2) women who have a child less than 15 months old who are not currently using a contraceptive.

Findings of this report are derived from 51 focus group discussions (FGDs). Fieldwork took place between February 26, 2003 and March 22, 2003. Two teams collected data. Each team consisted of a professional researcher to moderate the FGDs and a note-taker. Both were responsible for screening and recruitment of participants for the different FGDs. The following table presents the distribution of the FGDs by targeted groups and locations.

DISTRIBUTION OF FOCUS GROUPS

Category	Location	Age	FGDs #
Women Who Have Spaced Births	Peri-urban Cairo	15-22 23-35	2 2
	Sohag City	15-22 23-35	1 1
	Minia City	15-22 23-35	1 1
	One Village in Sohag	15-22 23-35	1 1
	One Village in Minia	15-22 23-35	1 1
Subtotal			***12***
Women Who Have Not Spaced Births	Peri-urban Cairo	15-22 23-35	2 2
	Sohag City	15-22 23-35	1 1
	Minia City	15-22 23-35	1 1
	One Village in Sohag	15-22 23-35	1 1
	One Village in Minia	15-22 23-35	1 1
Subtotal			***12***

Category	Location	Age	FGDs #
Husbands	Peri-urban Cairo	15-22 23-35	2 2
	Sohag City	15-22 23-35	1 1
	Minia City	15-22 23-35	1 1
	One Village in Sohag	15-22 23-35	1 1
	One Village in Minia	15-22 23-35	1 1
Subtotal			***12***
Mothers-in-law	Peri-urban Cairo Sohag Governorate Minia Governorate	30 – 60	3 3 3
Subtotal			***9***
Health Providers of Reproductive Health Services (Physicians/Nurses)	Peri-urban Cairo: *Physicians* *Nurses*		 1 1
	Sohag City & Minia City: *Physicians* *Nurses*		 1 1
	Village from Sohag & Village from Minia: *Physicians* *Nurses*		 1 1
Subtotal			***6***
Total number of Focus Group Discussions			***51***

The study consisted of 51 focus group discussions (seventeen in each governorate) with an average of eight participants in each group. All focus group discussions took place in the local health facilities, as they were convenient to reach by participants, comfortable and had electrical outlets for audiotaping. Each focus group discussion took between one and a half to two hours to be completed. Refreshments were served and costs of transportation were reimbursed.

The screening and recruitment of the FGD participants was carried out one to two days prior to the scheduled time of the session and each research team was responsible for this task within their respective governorate and was assisted by local staff. A specially designed screening form was developed to identify eligibility for participation in specific FGDs. During the process of soliciting their consent to participate, objectives of the study were explained as well as time and place of the meeting. Ineligible women or those who did not give their consent, but were within the age brackets, were asked for the names of their husbands and mothers-in-law, if available, so that they could be solicited for participation. The starting point for the recruitment process was the local rural health unit or maternal and child health center. Women attending those clinics for the purpose of receiving medical checkups for themselves or their children, for child immunization or for receiving family planning services, were eligible for the screening. Others were screened and recruited through door-to-door canvassing.

Focus Group Guidelines

The focus group guides were structured the same for all participants (female spacers and

nonspacers, husbands, mothers-in-law and health service providers) according to the following organization:

- Individual level (knowledge, beliefs/attitudes, practices)
- Cultural level (norms)
- Institutional level (service)
- Information sources

Consent Considerations

All participants who participated in this study were informed of the background and objectives of the study and were approached for consent to participate in the focus group discussions. They were also informed that their identities would be concealed, but their views and opinions could be included in the study. Group consent was also sought prior to audiotaping of sessions.

Data Analysis

All audiotapes were transcribed making use of the note-taker's notes to link each statement to the participant who made the statements. Transcriptions of the sessions were summarized and translated into English, although some transcripts were summarized directly into English. The software EZ-Text was used to process data from each focus group. It is a new qualitative software program developed to assist researchers in creating, managing, and analyzing semi-structured qualitative databases. EZ-Text helps solve the problem of consistency across interview write-ups by allowing the researcher to design a series of qualitative data entry templates tailored to each question. The program supported processing and content analysis of the transcripts.

The analysis for each set of FGDs followed the structure of topics in the Moderator Guide by integrating findings from each of the groups with spacers, nonspacers, husbands, mothers-in-law and health providers. Then the findings from each of the target groups were compared to each other.

IV. PRESENTATION OF RESULTS

A. MAIN FINDINGS

Optimal birth spacing between pregnancies has generally been stated as being between two and three years in order to accommodate the *"resting"* period. The resting period allows the mother to regain the calcium, iron, and vitamins that have been lost from her body through pregnancy, labor and lactation, and it provides time for the last born to receive full lactation and care. A healthy and relaxed mother is crucial for the care provided to the last-born child and the next to be born, and for the psychological and financial contentment of the husband. The health of the mother, the well being of the last child, and the financial situation of the family are all factors which influence the decision for spacing pregnancies.

Pregnancies occurring without the appropriate resting time of at least two years were considered to be risky by almost all participants in the FGDs. However, preventing potential problems during pregnancy, delivery and the neonatal period were not clearly considered as part of the advantages of spacing. They were only mentioned when direct questions

were asked about what would happen to the mother and the newborn if spacing were less than two years from the last-born child.

Among all of the groups (women, men, mothers-in-law and providers) there was great consensus that it is much easier for a woman to know when to get pregnant next than to calculate when the next child should be born. Thus, birth spacing should be explained in terms of when a woman should consider getting pregnant after the birth of the last child, not when the next child should be born.

Opinions differed as to who decides when to become pregnant with the next child, with some who believe it is the woman's decision, others the decision of both partners together and still others the decision of the husband alone. If it is the husband who decides on the timing of the next pregnancy, the responsibility still lies with the wife to try to convince him otherwise if she is not happy with her husband's decision/opinion. However, participants recognized that both partners always have some power over the other since the wife can use or discontinue the use of contraceptives without the husband's knowledge and the husband can threaten to remarry if unsatisfied with his wife.

In general there is more pressure on younger women not to space, based on the argument that women should have children when they are young and healthy and when their husbands are still young and strong to be able to control the children. Wives with less education, of rural Upper Egypt and with rural backgrounds may have less autonomy and less negotiating power and/or fewer skills to reduce such pressures. To ameliorate pressure on women, husbands, mothers, and mothers-in-law should be targeted with messages to make them aware of the health hazards that close spacing can cause for women and children.

Neither Islam nor Christianity contains teachings against birth spacing, but rather both encourage couples to space their children. Muslim couples in Egypt are generally aware that Islam encourages breastfeeding for two years, which defines the minimum spacing period. Yet longer birth intervals may still be desirable for some families but not for others. Age of the wife, order of the next child, sex of the living children, working status of the wife, and desired number of children are all factors that may affect whether or not such an optimal period of spacing is considered desirable.

The physician is the most important source of information on birth spacing for women and their families. Nurses responsible for counseling, as well as messages on television that reach all family members are also valuable sources of information. Recently, there have been television campaigns that encourage spacing, but they do not address "at risk" pregnancies, the optimal birth spacing period or post-partum contraception. Furthermore, public service messages are limited in their effectiveness by the fact that public family planning and reproductive health service providers do not have written guidelines for optimal birth spacing. Physicians specifically, need scientific evidence to be convinced of the importance of implementing the spacing guidelines.

B. ADVANTAGES AND DISADVANTAGES OF BIRTH SPACING

Popular Terms for Spacing

The most popular term for spacing in Egypt is the "*resting period*, "which refers to the period between one delivery and the following pregnancy *(Fatret Raha)*. Participants understood this term to indicate the period for a woman to regain her health and as an appropriate period for the last-born child to receive proper care and sufficient lactation. Other terms that were suggested to identify the period between pregnancies were: the *"period of convalescence" (Naqaha),* time-off or a break *(Hudna)* and family planning *(Tanzeem el Nassle).* Some husbands from peri-urban Cairo who are married to younger women added that such a period is a time for husbands and children to receive sufficient care from their mothers and wives.

Male physicians were more inclined to refer to this period of spacing with the Arabic term for planning (*Tanzeem)* as opposed to a "*resting time*" *(Fatret Raha),* which is a more popular term with nurses and female physicians. Planning (*Tanzeem)* sounded more serious as one physician explained. Resting, if mentioned to the mother, may be interpreted as waiting for a month or a couple of months, but *Tanzeem* indicates waiting longer and selecting the suitable time for having the following child. *Hudna* was also mentioned by a few as a term that could be used as well as the term (*Hadana)* i.e., the nursing period.

Advantages of Birth Spacing

All of these ways of expressing spacing, whether for rest, for convalescence, for nursing and/or for planning, indicate in general terms the advantages of spacing or waiting. The ideal time for waiting from one delivery to the next pregnancy cited by the majority was from two to three years, including among health providers. In Upper Egypt more participants were inclined to mention a two-year interval between pregnancies as ideal, in comparison to the participants from other areas who mentioned three years as the optimal interval. A few female spacers and nonspacers, husbands and mothers-in-law extended the period beyond three years to four, five or six years of waiting. A few physicians also extended the period of waiting to four or five years. The longer waiting time was considered to accommodate the high rise in the cost of living and/or time to allow for the last-born child to be old enough to enter school at the time of the arrival of the next child. Connecting spacing to the cost of living led one young non-spacing mother to declare that a well-off father, capable of covering family expenses and the needs of the last born and new child, does not create the need to wait more than one year for the next pregnancy.

The period of waiting or the *"resting period"* can have many potential physical, psychological and financial benefits for the mother, the last-born child, the husband and the next child.

For the Woman

There was a general agreement among participants that the waiting period gives the mother time for her body to rest and recover from pregnancy, delivery and lactation, as her body regains what was lost in terms of nutritional elements such as calcium, iron, and vitamins. The resting time also allows the uterus to return to its natural form. Psychologically the woman may be less exhausted and calmer if she has adequate time to take care of herself, her home and her family. With a more healthy and relaxed mother these benefits positively affect the well-being of the child and the whole family.

> *"When a mother is in good health she can have a healthy child and when she is physically well she can provide her husband with comfort so he will be able to work and bring in good money" (older spacer from Upper Egypt).*

For the Last Born Child

When births are spaced, the last-born child receives more attention, comprehensive care and adequate lactation. This comprehensive care includes proper hygiene, appropriate feeding, clothes, love, affection and timely medical treatment. These advantages will ensure that the child grows up physically, mentally and emotionally healthy with greater immunity against illnesses. The last-born child may also avoid being jealous of a younger sibling sharing the mother's attention and taking away part of his/her needed care. As a Cairo physician summarized:

> *"A good mother equals a good child."*

An older spacer in Cairo explaining the importance of lactation, said:

> *"When a baby is breastfed for two years as God said, he will eat well, dress well, enter school and be good among his classmates."*

For the Partner

There are also advantages of delaying pregnancy for the father/husband. With children spaced farther apart, the father/husband may be more psychologically and financially comfortable due to the fact that he and his wife/partner have fewer young children that need attention and financial support. Some of the participating mothers-in-law added that spacing could provide husbands with the opportunity to save and provide a better standard of living for the family. Many participants across the focus groups also mentioned that the husbands might be less apt to remarry if they are comfortable with their current partners.

For the Newborn Child

Participants across the groups cited advantages of spacing for newborns only when prompted by direct questions. In other words, no one mentioned advantages to the newborn when discussing why a woman should wait the specified period of time between the last birth and the following pregnancy. Advantages for the newborn were only mentioned when participants were asked directly for advantages and/or disadvantages of the *resting period* for the next child to be born.

The advantages for the newborn are related to the benefits accrued from the health status of the mother when pregnant and the general status of the family when born. Health advantages for the newborn include: nutritional quality of the breast milk, full-term delivery, normal birth weight and sufficient calcium. A well-nourished and relaxed mother's breast milk will be more adequate for the new baby's needs in quality and quantity.

> *"She [the mother] would be breastfeeding the first child for so many months and if she is pregnant again the second baby's milk will be weak." (older spacer from rural Upper Egypt)*

Additionally, the new baby will be born in a family that is better prepared to receive him/her. The parents may be more available and better prepared financially. The older sibling will also be of an age to develop a strong relationship with the next child.

Views on Complications

When asked directly for the effects on the mother and newborn if the mother becomes pregnant within two years of the birth of the previous child, participants reported a myriad of problems for the health of the mother and newborn, including the possibility of maternal and/or neonatal mortality. The health dangers that women with children spaced too close together can experience as reported by participants are: miscarriage due to a weak uterus; pregnancy toxemia; excess albumin that could cause edema in her legs; hypertension; and/or premature delivery. During delivery the woman may experience difficult and prolonged labor due to weakness or breech presentation, she may deliver through cesarean section or experience rupture of the uterus and she may suffer from septicemia. After delivery the mother who does not space may suffer from general weaknesses, dizziness, hypotension, weight loss, headaches and back pain, among other physical problems.

Mothers-in-law were able to state the greatest variety of problems and ailments occurring in women who do not *"rest,"* and they provided real examples of such sufferings. These included the following:

- A woman was delivering when *"her uterus fell and they removed the uterus with the baby."*
- One suffered from *"albumin in the urine and the child was so black and not awake and the doctor put the baby under tap water."*
- One woman was used to having babies within a year of delivery, *"she experienced difficult labor, high blood pressure and inflammation in her kidney that she treated for 12 years. Because she did not rest after delivery due to all her responsibilities, she twice had sepsis."*
- One suffered from bleeding in her sixth month of pregnancy and took injections until the bleeding stopped.

In spite of these ailments that were mentioned within each group, a few clung to the notion that the incidence of these ailments depended on the health and nutritional status of the mother. Many reported that they knew of women who had become pregnant again quickly after the birth of a child and had not experienced any health problems. Several participating physicians and nurses stated that the incidence of health problems depends on the number of pregnancies that the woman has experienced, and that the characteristics of women who experience complications are variable. As one physician from peri-urban Cairo stated:

> *"In reality, some women become pregnant after 40 days and they deliver a very healthy child."*

Disadvantages

Stated disadvantages of spacing were minimal and mentioned by only a few participants. Some younger female spacers from peri-urban Cairo mentioned that the last-born child might become jealous when the mother's attention is diverted to a newborn after a long period of being the youngest child. Both spacers and nonspacers also mentioned that they

had experienced negative side effects from contraceptives used for spacing. Some women felt that older women who had long intervals between children may also have difficulty in conceiving and delivering the next child.

Additionally, some participants reported that husbands who favored having many children *(Ezwa)* might use a mother's desire for spacing as an excuse to remarry. The husband may also be criticized by community members as in rural Sohag where one husband said that he had been frustrated by phrases such as, *"You did not get a boy, there must be something wrong with your wife,"* when his wife did not become pregnant soon after the birth of a girl.

C. DECISION MAKING PROCESSES AMONG COUPLES ON THE TIMING OF PREGNANCIES

The focus group discussions did not reveal any set pattern for decision-making among couples in regards to spacing. Answers about who decides on the timing of pregnancies varied from both partners, to only the woman or the man to God's will.

Women's Opinions

Main findings were the following:

- Among spacers and nonspacers in peri-urban Cairo and urban Minia and Sohag, the majority stated that the decision to space was a joint decision of the husband and wife, especially among the older participants.
- A few women believed that the wife has more control in the decision-making process.
- Among the younger groups of women spacers in urban areas, there was a greater tendency to state that the husband decides on spacing.
- Among young nonspacers, the majority also claimed that the husband is the decision-maker, particularly among those in rural areas.
- Older nonspacers in urban and rural areas stressed that spacing is a joint decision, and to a lesser extent, the wife's decision.
- A few older nonspacers mentioned that the decision to space rests with the husband, more so in the rural rather than urban areas.

Thus, in general, age, experience with spacing and urban residence seem to indicate greatest decision-making power for the wife.

Even if it seems that a woman does not have control over the decision to become pregnant if her husband wishes to have another child, women may still try to convince their husbands to delay pregnancy. Similar to what mothers-in-law said, a few spacers noted that if necessary, women could use contraceptives without their husbands' knowledge.

Nonspacers, especially the younger women, agreed that they do have a voice to convince their husbands of their desire for spacing. If the husband does not agree, however, these women also said that they might use a contraceptive method without their husbands' approval. Others said that they would have to give up because they *"cannot say no."* Older nonspacers stressed that they do have a voice in the decision to space, but they still have to gain approval from their husbands.

Many participants from urban and rural Minia reported that they would never use contraception without their husbands' knowledge. Only one woman from urban Sohag and

one from rural Sohag reported that their husbands would understand their need for spacing in order to rest. One woman said that her husband told her to *"find a method to use if you are tired."*

Men's Opinions

While husbands of older women were more inclined to profess that both partners decide when to get pregnant with the next child, husbands of younger women stressed the role of the husband in such a decision because of the nature of their financial responsibilities within the family. A few husbands, most of whom were married to older women, stated that the decision concerning pregnancy is the woman's decision and she is the one that uses contraceptive methods because she bears the suffering of the pregnancy. Only one husband from urban Minia out of a total of 12 focus groups ended the discussion with the statement that pregnancy is neither the man's nor the woman's decision, but rather is based on the will of God.

For husbands, the extent to which pregnancies are planned and do not just happen varied. Husbands married to younger wives and living in rural areas of Upper Egypt, tended to believe that pregnancies just occur. All others, with few exceptions, agreed that couples decide together when a pregnancy should take place. Some understood the concept of *"planned pregnancy"* in terms of artificially postponing pregnancies through a form of contraception. They were of the opinion that illiterate communities, newly married young couples, couples who value children *(Ezwa)*, those who believe in God's will and those that believe every child is born with a fortune *(Rizk),* do not or should not "plan" pregnancies.

Many of the men believed that a wife's role in deciding on the spacing of the next pregnancy is to tell her husband her opinion, but to respect the husband's decision as final. Husbands said:

> *"If my wife has a say, then there is no need for me."* (husband of a younger wife from peri-urban Cairo)
>
> *"If she has a different opinion, I would go and marry another."* (husband married to an older wife from peri-urban Cairo)
>
> *"If she does not follow her husband's decision, they may end in separation."* (husband of a younger wife from urban Minia)

Opinions of Mothers-in-law

The majority of mothers-in-law were of the opinion that both husbands and wives decide on spacing together. The few mothers-in-law who mentioned that it is the husband's decision and the wife's role to obey, were from rural areas.

Those mothers-in-law who believed that the wives have control over the spacing of their pregnancies stated that a wife's control came from the fact that she could use contraception without her husband's knowledge, or, conversely, she could stop using a contraceptive method without telling her husband if she desired to become pregnant again. If she became pregnant she could say that, *"it was a mistake"*. One mother-in-law said it was a wife's decision *"to tie the man with children."* Only one mother-in-law in a rural area in Sohag said that, *"it is no one's decision, it is God's will."*

Opinions of Health Providers

Almost all health providers in Upper Egypt, in rural and urban areas, believed that the spacing of pregnancies is the husband's decision. Physicians in rural Sohag also mentioned mothers-in-law as possible decision-makers. A few providers stated that the couple makes the decision together or that the wife is the one who decides as she is the one that will become pregnant. Providers in Cairo were divided between those who thought that spacing is a couple's decision and those who thought that the man has the decision-making power. One physician from peri-urban Cairo who stressed the role of the husband said:

> *"A woman came to the clinic the day after she had inserted an IUD to remove it according to her husband's will."*

Providers in Upper Egypt believed that women do not have a say in reproductive health decisions unless they are more highly educated, have experienced health problems during previous pregnancies, or if they strongly desire to have another child. They stated that husbands generally make the final decision because they control the family's finances, whereas in Cairo providers viewed the woman's decision-making power as dependent on the nature of the relationship between the husband and wife.

Regardless of who controls the decision, the final decision for pregnancy is reported to be made after discussion and planning between the couple. Even if opinions differ, each partner has to convince the other. A few providers mentioned that if the husband wants children for (*Ezwa) "*family power and support," or if influenced by his mother, then he continues arguing with his wife.

Hence, decisions regarding the timing of the next pregnancy are a function of both partners. If opinions differ, the responsibility is on the wife to convince her husband. If such a consensus does not happen, each partner has access to a power strategy. The husband can remarry or separate, and the wife can control her fertility through secretly using or not using contraception.

D. ACTUAL BIRTH SPACING PRACTICES

Women's Views

The main methods that women in Egypt use for spacing are modern forms of contraception or lactational amenorrhea (LAM), "*clean lactation"*. For spacers, the majority relied on modern contraceptives, while a few relied on *"clean lactation"* (one in each of the young and older groups in peri-urban Cairo, an older group in urban Minia, and a younger group in urban Sohag). Additionally, five of the younger participants from a rural area of Sohag who had children spaced two or more years apart, considered the spacing to have been the will of God.

Those participants who would have liked longer intervals between their pregnancies, mostly from Upper Egypt, stated that they had been influenced by their husbands, mothers-in-law or their own mothers, had discontinued use of a contraceptive method because of side effects or had experienced method failure. Illustrating the influence of husbands, one young spacer from urban Sohag said:

"My husband threw the pill out the window and told me, 'I want children.'"

Nonspacers mainly said that they would have liked longer spacing between pregnancies for the sake of their health. Only four nonspacers, all from rural Upper Egypt (3 older and 1 younger) did not want to wait longer between pregnancies because they wanted to have children *"one after the other"* or wanted a child of a specific sex, a boy or a girl. The main impediment to longer spacing was reported to be that women were encouraged to discontinue use of contraceptives because of negative side effects. The second main factor was the belief in *"clean lactation"* and thus not using any other contraceptive method to protect from pregnancy. A third reason given was related to the husband and/or the mother-in-law's desire for the wife to have children while she was still young.

The term "clean lactation" refers to a woman who is breastfeeding and still in a period of postpartum amenorrhea. Nonetheless, since ovulation occurs prior to the return of menses, a woman can become pregnant before experiencing menstruation.

Problems reported from the use of contraceptives varied:

- Oral pills affected lactation, were often forgotten, caused bleeding, or made them feel weak.
- IUDs caused bleeding, inflammations, and one older participant from rural Minia experienced an IUD "*that moved up"* and was removed only after she was *"X-rayed."*
- Injectables caused bleeding, headaches and high blood pressure, and one participant said that she *"could not stand"* on her feet from the injections she took.

A number of factors were listed by nonspacers that would have helped them to space their pregnancies better. Those who had used LAM suggested that using a second form of contraception could have helped them to not get pregnant again so quickly. Another factor was the need to convince husbands and mothers-in-law of the benefits of adequate spacing. Additional factors were related to greater familiarity with existing contraceptives and fewer negative side effects from contraceptive use. Women also mentioned that they would be more likely to space if certain beliefs were not held, such as children binding men to their families, preference for children of a certain sex, especially boys, and the urgency of having children while young in age. Three older women from urban Minia stated that if men accepted the condom, then women would be free of health problems related to contraceptives. However, they added that men of Upper Egypt have traditionally refused to use condoms.

Men's Views

In the focus groups the majority of husbands stated that their wives were already using contraceptives to space or to stop child bearing. More than one-third stated that their wives were using IUDs, approximately one-fourth reported that their wives were using injectables, less than one-fourth of their wives were using oral pills and one husband stated that his wife inserted capsules. Of those whose wives were not using any contraceptive method, two of the wives were already pregnant, 3 of the wives were intending to seek a method, one wife was breastfeeding and two stated that their wives were *"naturally"* not pregnant.

For the most part, husbands placed the blame on their wives for not waiting the reasonable time before getting pregnant again. The men believed that women might become pregnant to increase their husbands (*Ezwa)* power, or as a means of tying their husbands to the family so that they would not seek new wives. Other reasons stated for women's lack of

spacing was to satisfy the husband's wish for a son. If not, this could be a reason for the husband to look for a new wife.

Additionally, failure to space children, according to a few of the husbands, could be due to the *"will of God"* or women not taking their oral pills or injectables unintentionally or intentionally. Some rural husbands married to older women (22-35 years) added that some women prefer to have their children when they are young, they do not realize the danger to their health from too frequent child bearing, they become pregnant while lactating, or they stop using contraception because of negative side effects.

Involvement of the Mothers-in-law

When the mothers-in-law were asked whether they would like their daughters-in-law to practice birth spacing, most said that they did not interfere in the decisions of the couple, although they did have their own opinions. Some of the participants were satisfied with the spacing of their grandchildren while others wished that their sons and daughters-in-law would have more children with closer spacing between births. One mother-in-law stated:

"I want to see my son's children before I die."

In Upper Egypt, more of the mothers-in-law said that they would have liked their daughters-in-law to have longer birth spacing intervals so that they would be better able to take care of themselves, their husbands, and their children. However, there was a general attitude among mothers-in-law that their daughters-in-law do not listen to them. Mothers-in-law believed that they could give advice, but it is up to the daughters-in-law whether or not they heed the advice. None of the mothers-in-law mentioned influencing daughters-in-law through convincing their sons. However, a young spacer explained the influence of the mother-in-law on the husband:

> *"I tell my husband I want to insert a method, he says O.K. and when he goes to his mother in the morning, he comes and tells me to forget about the IUD." (young non-spacer from peri-urban Cairo)*

Providers' Views

Health providers confirmed a number of factors that influence whether women and men in the communities they serve wait for two to three years or one to two years to become pregnant again. The length of the period is affected by the type of contraceptive used and the side effects experienced, in addition to relying on *"clean lactation,"* which often fails to prevent pregnancies. The spacing is also affected by the desires of husbands and their mothers. However, opposite of what was mentioned that younger wives are less inclined to have longer intervals, health providers believed that older women were less likely to practice birth spacing because they feared losing fertility, especially if they still desired to have more children. A physician from rural Sohag stated:

> *"In the locality where I live, 80% are satisfied after the 3rd child, 90% are satisfied after the 4th child and the fifth is usually a mistake."*

They all agreed that postponing pregnancy for longer periods usually occurs after the birth of the second child rather than the first, because after the second the woman feels *"satisfied and not hungry"* as one nurse from urban Minia stated. However, nurses from

urban Sohag also reported that there are families who want to have a child every two years regardless of the order of the child.

In sum, couples prefer to have children spaced at least two years apart, and using modern contraception is the most practiced means of postponing pregnancies. Nevertheless, the main factors influencing the achievement of longer birth spacing intervals are method failure from non-compliance, discontinuation because of side effects experienced, and failure of LAM.

E. MOST RECOMMENDED/REQUESTED CONTRACEPTIVE METHODS

The majority of health providers from Cairo reported that the IUD is the most preferred contraceptive method by many women because it is effective, nonhormonal and does not affect lactation. In addition, if a woman wishes to become pregnant she only has to have the device removed. Women who request injectables are usually those who experienced bleeding from IUDs or heard about other women who did. They usually have more than one child and they are comfortable coming once for the injection and forgetting about it for three months. A few nurses added that they counseled women that use of injectables could result in delayed return of fertility.

Health providers in Upper Egypt believed that women prefer injectables, followed by oral pills and then IUDs, particularly if the physician to insert the IUD is a male. Providers stated that women prefer injectables because they are cheap, available and do not affect lactation, whereas women have many misconceptions about the side effects caused by IUDs. Injectables have also been promoted on television, which has increased their demand. Providers said that those who prefer the oral pills believe that they are cheap, available, are easy to discontinue at any time and allow women to become pregnant immediately following discontinuation.

Female spacers and husbands indicated that the most commonly used contraceptive is the IUD, followed by injectables and then oral pills. Participants did report that switching contraceptives from IUDs to others does occur because of side effects.

However, when husbands were asked about the methods that men prefer, those married to older women agreed that it is the physician who decides on the method according to what is appropriate for the woman's health. Still, some husbands did state their opinions. Less than half of those who stated their opinions preferred injectables because they *"prevent menstruation"* and are not prone to being forgotten, as are oral pills. More than one-third of the men who reported a preference thought that the IUD is the best contraceptive method because it is safe and can last for long periods of time, up to nine or ten years. One in six of the husbands preferred the oral pills because they are easy to use and cheap. One husband from rural Sohag mentioned that some men prefer the methods that do not prolong menstrual bleeding because that affects their sexual relationships.

As for husbands married to younger women, only a few from Upper Egypt mentioned that the method should be decided upon as per physician advice as all modern contraceptive methods have their advantages as well as their disadvantages. One participant from rural Sohag said that it is better to rely on *"natural*" methods provided by God, meaning LAM. Of those who had a preference, less than half preferred the IUD, more than one-third preferred injectables, and more than one-fourth preferred oral pills. The IUD was preferred because it is an effective contraceptive method for a long period and not prone to forgetfulness as oral pills or to the same side effects that lead women to stop taking them. Additionally, an IUD is

cheaper than injectables and the woman can remove it when she wants to become pregnant. Injectables were preferred because they cannot be forgotten as oral pills. Oral pills were preferred because they are cheap and do not bother the man during intercourse.

Husbands from urban Sohag stressed the fact, as did husbands of older women, that IUDs restrict their sexual relationships because of prolonged menstrual bleeding and that IUDs disturb them during intercourse. Furthermore, husbands from urban Minia mentioned that men feel it is degrading to use condoms as a contraceptive method.

Hence, IUDs and injectables rank first and second on the basis of husbands' reaction to menstrual changes caused by the method. Oral pills, ranked third in preference by husbands, are still widely-used mainly because of cost and the fact that women may feel they have greater control as to when to discontinue use to become pregnant.

Participating family planning health providers were highly convinced of the appropriateness of IUDs. Health providers recommend the IUD because it is a localized method, non-hormonal, effective for 10 years and does not affect lactation. Side effects of IUDs are considered minor by health providers and can be easily managed. They also believe that an IUD does not affect sexual relations between the man and the woman. Additionally, an important advantage as viewed by health providers is the fact that a woman can become pregnant immediately after an IUD is removed.

Some providers also promote implants because they lack serious side effects. Though providers are aware that injectables are in demand, they generally only recommend them for women who are older in age and have had their intended number of children because they are convinced that injectables affect fertility and women have to wait for a long time after discontinuation before they become pregnant, if they ever do.

F. INFLUENCES ON THE TIMING OF PREGNANCIES

Family

A couple's family tends to influence the timing of pregnancies, particularly among younger women as reported by spacers and nonspacers. The majority of the pressure, as stated by women, comes from mothers-in-law. Mothers-in-law pressure their young daughters-in-law to become pregnant quickly *(alatool)* and they convince their sons of the need for closely spaced children so that they can see their grandchildren before they die. Also, many mothers-in-law stated that they believed children should be closely spaced so that they "grow-up together." Female spacers and nonspacers reported that their mothers tended to be more concerned about their health and well being than their mothers-in-law.

In general, female spacers reported that their families tend to support a waiting period of 2 to 3 years between pregnancies, although in Upper Egypt some participants mentioned a shorter period as desirable. In rural Sohag older spacers indicated that their families tend to agree on the optimal space between pregnancies as two years if the last-born is a boy and 18 months if the last-born is a girl.

Nonspacers were divided in terms of the accepted time for waiting among their families. In peri-urban Cairo, the ideal interval between pregnancies dictated by family members ranged from 18 months to four years, with the majority of mothers-in-law recommending a two-year interval to allow for proper breastfeeding. In Sohag participants reported that the interval preferred by families ranges from 40 days to one to one a half years to two years to

a three year maximum. In Minia, all urban young nonspacers declared that their families want children to be born right after each other *(wara baad),* which means that they are expected to become pregnant after the 40th day post-delivery or two months. One 22 years old woman reported a mother-in-law as saying after a month of delivery:

> *"Collect your strength (Helek) and bring him a brother (Khaweeh) before you get up from this bed (Farsha) you are sleeping on."*

In rural Minia the majority of young nonspacers mentioned that their families prefer a waiting period of two years, while older nonspacers indicated that the ideal interval was three years. Older nonspacers in urban Minia stated that the optimal interval in their communities ranged from two to four years.

Pressures on wives for more frequent pregnancies as reported by women come mainly from husbands and mothers-in-law and occasionally from sisters-in-law and mothers. Mothers-in-law were reported to say:

> *"Women who do not get many children are like barren land (Boor)."*
>
> *"Children support the father's back."*

Such pressures are more dominant in societies where extended families live together or nuclear families live nearby extended family, which tends to be the case in Upper Egypt, especially in rural areas. Families tend to argue that women should have children closely spaced while they are young and healthy and then rest when the children are older. Families argue that closely spaced children will grow-up to look as if they are the mother's siblings and not sons and daughters, and siblings will have close ties to each other when they are close in age. In addition, mothers who encourage their daughters to have more frequent pregnancies tell their daughters that children tie down the husband.

If a woman does not become pregnant quickly, families use the threat of being "sent home to her family" or of her husband remarrying as a means of pressuring her. The continuous threats can create immense psychological strain on women.

Husbands also confirmed the preference of mothers-in-law to see their grandchildren and strengthen the family power *(Ezwa).* Nevertheless, most husbands negated the influence of their mothers because only *"men with weak characters are influenced by their mothers,"* particularly in regards to issues that relate to past traditions. Yet husbands pointed to the significant influence of the women's mothers as they push their daughters to *"bind"* their husbands.

Nevertheless, husbands confessed that mothers-in-law sometimes subject their daughters-in-law to criticism, especially if they do not bear children or wait for more than two years between pregnancies. One husband from rural Minia related how his mother would tell his wife:

> *"We brought you here to eat, sleep and reproduce or else I will get my son another wife."*

Mothers-in-law, however, refuted these accusations. They insisted that they have no say in pregnancy decisions. Yet, some did not deny their wish to see their sons' children. They suggested that their role is to give advice and not orders, and they denied that families exert pressure on couples. Instead they stated that the main pressure on women comes

from husbands who prefer shorter intervals because they threaten to remarry if the woman does not become pregnant. On the other hand, some mothers-in-law from peri-urban Cairo admitted that families are concerned when pregnancy is delayed and they may take their daughters-in-law to physicians for medical examinations.

In spite of the denial by mothers-in-law that they exert pressure on daughters-in-law, healthcare providers confirmed that women are often subjected to pressure and threats from husbands and mothers-in-law. Healthcare providers estimated that mothers-in-law influence approximately 50 to 90% of pregnancy decisions, while husbands influence about 90% and women's mothers influence pregnancy decisions in about 10% of cases. Family influence was found to be greater in Upper Egypt.

Nevertheless, there was consensus among providers that these pressures are decreasing as women become more educated and have greater autonomy and more influence over the views of their husbands. Also, increasing financial pressure from a rising cost of living has made people more aware of the benefits of delaying pregnancies.

Further community pressures were mentioned in terms of women comparing each other and pitying women without sons.

Cultural Influences

There are clear cultural influences that may encourage or limit optimal birth spacing. The authority of the husband as the financial provider and the power he has to *"send the wife back to her family"* or to remarry if the wife does not conform to his demands encourages the wife to reduce the waiting time between pregnancies in order to please the husband. In addition, giving birth to a baby boy could lower pressure for a subsequent pregnancy while giving birth to a baby girl may have the opposite effect.

Strong extended family relationships can increase access of the nuclear family to social, emotional and economic support from extended family members. On the other hand, extended family members may feel responsible to ensure that the couple stays within the normal and expected track. Hence, interference by extended family members into the private affairs of a couple is expected and accepted, although it may sometimes contradict the desires of the couple. Particularly for young, uneducated women, this interference reduces their autonomy for decision-making.

Additionally, the strong belief in the concept of *"clean lactation"* is a factor that unintentionally may reduce the period of waiting for the next pregnancy. Though the majority believe that breastfeeding is a natural contraceptive until the occurrence of the first menstruation, there are a few, mostly men, who believe that breast milk is a gift from God and as long as it flows, it will be a God given method *(Wassila Rabani).*

The concept of *Ezwa* or family power, where valued, also influences the waiting time for couples, when husbands and mothers-in-law want to have children and grandchildren quickly, before the wife is beyond reproductive age.

Finally, the societal norm that allows husbands who are not satisfied with their wives to abandon them and remarry increases women's anxiety to contradict their husbands. Many participants felt that a woman who has provided her husband with the desired number of children without complaint is less likely to be subjected to these experiences. This norm

also increases the influence of the mother-in-law as she can use the possibility of abandonment as a threat to encourage obedience and conformity of the daughter-in-law.

Religious Beliefs

There was general agreement among women, husbands, mothers-in-law and health providers that Islam and Christianity encourage a *"resting"* period for the health of the mother and the child. Christianity encourages spacing but does not specify time. Islam, however, clearly specifies breastfeeding for two years. Some participants, including all healthcare providers, were aware that Islam specifies a two-year time-period for lactation before the next pregnancy, which allows for a period of three years before the next delivery. Yet some participants believed that the teachings of Islam specify a duration of two years for lactation, but do not mention an optimal interval between births.

G. HEALTH SERVICES AND BIRTH SPACING INFORMATION

The majority of participants indicated that women most often receive health services from public health clinics. Some participants reported using private health services mainly for antenatal care and to a lesser extent for deliveries. A few participants had visited clinics run by NGOs *(Mostawsaf)*.

As for differences in information received between public and private health providers, most participants believed that the differences between services depended on the quality of the providers and not the place. Some participants find that public health providers are better than private, as they give more information, better counseling, and administer more routine tests. Those who prefer private providers perceive that they provide a higher standard of care because they are not free of charge and are not as crowded as public clinics so they provide better care and more information. A few mothers-in-law in Minia reported that their daughters-in-law only go to private clinics because of the availability of ultrasound machines.

Women

Among spacers from peri-urban Cairo, most did not receive any information on spacing during the visits they made for health services. Women in Sohag and Minia were provided with some information on spacing, but participants did not specify the exact nature of this information. A few participants did report that they were told by providers that the optimal period for spacing between pregnancies was for two to three years in order to regain physical and psychological health and give the needed care and lactation to their last born child. Some spacers said that they were given this advice because they had other health problems, and that providers told them that contraception was the means to postponing pregnancy. All those who received such information from service providers were introduced to the IUD, although some were also presented with other methods, such as oral pills, injectables, condoms, and/or capsules, and were told about the advantages and disadvantages as well as the side effects of each.

As for nonspacers, a few received information on delaying their next pregnancies, although the majority did not receive any information. Of those who were given information about delaying pregnancy, providers proposed two to three years as the optimal space between pregnancies. Only one participant from peri-urban Cairo mentioned that she was told that

spacing has the potential to reduce complications during pregnancy, but there was no mention of decreased labor complications or benefits for the newborn.

Of the nonspacers who were told by providers about avoiding pregnancies, all were presented with the advantages of the IUD but were not made aware of the possible side effects. There was one exception to this from Minia where one woman was told she would not be able to carry heavy weights if an IUD was inserted. Injectables were also presented, but some participants reported that they were told injectables are not suitable for younger women. When condoms were presented, the message to women was that they prevent semen from passage and can be used for a short duration. Oral pills, they were told, decrease breast milk and require good nutrition, while capsules were expensive. No one mentioned being told about potential menstrual changes as a result of using any of the contraceptive methods.

Mothers-in-law/Husbands

Most mothers-in-law did not know what information their daughters-in-law had received about birth spacing, or they stated that their daughters-in-law were not informed of anything. Husbands, however, were more informed. More than half of all male participants, particularly those married to younger women, confirmed that their wives received information on the optimal duration of resting and/or the advantages and disadvantages. The other husbands stated that their wives had not received any information on spacing.

The few mothers-in-law that were aware of the information their daughters-in-law had received about spacing said that they were told to rest for their health and the health of their babies, either by breastfeeding or by using a method to prevent pregnancy. The time for resting between pregnancies that was advised by physicians was two years or two to three years. Only one mother-in-law from urban Sohag mentioned that the recommendation by a provider was one to two years between pregnancies.

One mother-in-law from rural Sohag said the doctor told her daughter-in-law who was pregnant before adequate resting that *"this is wrong and difficult (Wa'ar) on you."* Because many of the mothers-in-law have relatively little knowledge of contraception it was difficult to discern if what the mothers-in-law interpreted was in reality what the health providers said. Among the statements were:

> *"She was told pills reduce milk."*
>
> "*She was told IUD causes bleeding and its insertion depend on size of uterus."*
>
> *"She was told that she is safe for two years because she is breastfeeding."*

Husbands whose wives had been told about birth spacing said that their wives were told to rest for two or two to three years before becoming pregnant again. That span was considered to be realistic by the majority of husbands. The few that did not think it was realistic were mainly married to younger wives, or thought that illiteracy and a desire for many children would prevent many couples from practicing birth spacing. Other husbands stated that pregnancy is determined by God and cannot be predicted or controlled.

Providers

All health providers stated that they always give women information about birth spacing, and the advantages it can have for themselves and the children. Nurses stressed that they explain to women the contraceptive methods available for spacing. However, nurses from rural Minia said that they do not specify a certain period of waiting between pregnancies as they leave each woman to decide according to her own circumstances. All other nurses and physicians said that they advise women to wait at least two to three years before the next pregnancy. Both nurses and doctors said that they talk to women about spacing after delivery when they *"still remember the pain,"* 40 days after delivery if they come for postpartum check-ups, during counseling for contraception and/or when women come to the clinic with their babies for immunizations. A few providers mentioned talking to women about birth spacing during antenatal care visits.

Providers considered that two years is a realistic waiting time unless women: are exposed to pressures from their families; marry late when long spacing durations may affect their capacity to achieve their reproductive intentions; are non-working mothers who enjoy having children; have experienced contraceptive side effects; or have experienced the loss of a child. With any of these circumstances, the providers felt that a two-year interval becomes unrealistic. However, two-years is a realistic goal for women to be able to complete the lactation period, for the last born to go to nursery school and for the family to be socially and financially ready for the next child.

Almost all providers agreed that explaining the period of waiting, as the time between the birth of one child and the next pregnancy rather than as the space between two deliveries, was a better way to explain spacing because it sounds shorter. Only a few nurses preferred explaining the time for a woman to *"take her breath and regain her health"* as the time between two deliveries.

Providers stated that there are no written guidelines provided by the MOH on what to tell women about birth spacing. There are a few words about spacing in the family planning service guidelines, but these guidelines do not specify the length of time a woman should wait before getting pregnant again after the birth of a child.

Providers were more willing to accept three to four years of waiting between pregnancies rather than five years of waiting, especially for women who start child bearing in their twenties. However, when asked who would be responsible for providing them with information to change the optimal birth spacing period from two to three years, physicians first wanted scientific proof of the benefits of three-year intervals from researchers authorized by the Ministry. Nurses thought that a responsible person from the Ministry, or even better the Minister himself, should announce the new norm. Nurses from Sohag suggested that a Ministerial decree, if possible, would be best.

Providers also stated that in order to implement new guidelines in their daily work, they prefer to receive information by participating in a training workshop, through booklets or brochures that provide research results, and/or by attending scientific conferences. In other words, providers need to be thoroughly convinced of the benefits of three-year intervals before they will endorse the change.

For providers, the most suitable time for providing counseling on birth spacing is right after delivery and during counseling sessions before or after a contraceptive method is used.

Some providers added that it is essential to prepare a woman to think about spacing after her delivery during antenatal check-up visits. Other providers stated that it is essential to talk to mothers about spacing when they come with their babies for vaccinations, which is currently how the majority of information on spacing is given to couples.

H. PREFERRED SOURCES OF INFORMATION

Almost all participants in all of the FGDs prefer receiving information on birth spacing from physicians. According to participants, physicians provide the *"correct information and opinion,"* because they have studied medicine, are experienced and know the health status of the woman. A few older women spacers added that they prefer receiving information on birth spacing from the nurses at family planning clinics. One husband from peri-urban Cairo stated the proverb: *"ask an experienced person rather than a physician."*

Television ranked second as a trustworthy source of information on spacing, while the radio was reported to be a valuable but less powerful information source. As stated by one young spacer*, "television makes one aware and shows the husband also instead of being ignorant."* Some participants suggested that dayas, midwives and pharmacists would not be considered trustworthy sources of information, except for those pharmacists with "Ask/Consult" signs. A few participants said that they would listen to relatives and friends who are knowledgeable, experienced and concerned. Leaflets and posters were also considered to be good sources of information, especially when endorsed by the Ministry.

Almost, all participants, including health providers, had seen television spots regarding birth spacing on Channels 1,7 and 8 (7 and 8 being Upper Egypt channels). Those mentioned were *"Ask/Consult," "The Wise Zeina (Agla)," "Zaki" and "Sehetna Bein Edena"* None of the participants reported receiving information on birth spacing from pharmacists. As for information contained within instructions in contraceptives packages, this was considered helpful and a good idea so that husbands would also be able to read it. Healthcare providers also thought that package inserts were a good idea for propagating spacing information and supporting advice given by providers.

V. CONCLUSIONS

Knowledge vs. Barriers to Practicing Optimal Birth Spacing

The knowledge and awareness that women, men, mothers-in-law and family planning and reproductive health service providers have in regards to the advantages of birth spacing or *"resting"* for mothers, the last born child, the next child and the father is relatively high. This knowledge is most probably a function of the counseling received, especially from nurses in family planning clinics, and from recent television messages. Participants were most aware of the benefits related to mothers regaining their health and replenishing lost nutrients, particularly calcium and iron, and protecting themselves from the stress and exhaustion of taking care of two young children in addition to their homes and husbands. In general participants felt that mothers who are well rested and healthy are more able to provide quality care including breastfeeding to the last-born child as well as a comfortable environment for the husband.

The most important reasons stated by participants for practicing birth spacing are the mother's health, the ability to better care for the children and the financial capability to cope

with increasing demands. Some husbands placed greater emphasis on the quality of caring for children and financial strain than on the mother's health.

Participants were aware that closely spaced pregnancies could be generally bad for a woman's health, though they did not necessarily know that a pregnancy that occurs too soon after the previous pregnancy is considered to be "risky," with health implications for the mother, the fetus and the newborn. However, when asked directly participants spoke of cases they had seen where problems occurred during pregnancy and delivery, and where the newborn had suffered from complications.

Despite general awareness of the dangers of closely spaced pregnancies, participants still had the following counterarguments against spacing pregnancies more than two years apart:

- Pregnancies are not planned, they happen according to God's will.
- Women who wait "too long" for the next child are considered *"barren"* and not necessarily wise.
- Couples who are financially comfortable can afford to have children without waiting for the *"resting"* period.
- If the mother is healthy and well nourished, she can afford not to wait.
- Waiting for more than 2 years for the next pregnancy better suits a working woman than a non-working woman.
- Giving birth to a baby girl will justify becoming pregnant quickly to increase the chances of having a boy.

Even when women are convinced that they should wait at least two to three years for the next pregnancy as they have been advised by health providers, they may be pressured against waiting by husbands, mothers-in-law and even mothers. It becomes the woman's burden to convince them of the advantages of spacing, which can be very difficult for a young newly married woman or a woman who is not well educated. Married women may have the chance to be counseled by health providers during their family planning and/or reproductive health visits, but husbands, mothers-in-law and mothers most likely do not have this option.

In order for more couples to practice optimal birth spacing, arguments against longer spacing must be addressed. For instance, young nonspacers found waiting two to three years to be unrealistic advice because they feel it will be rejected by their husbands, and some thought that if they waited that long their bodies would become unaccustomed to childbirth and they would need to give birth through cesarean section. A few mothers-in-law from Upper Egypt also reiterated almost the same idea that waiting for three years or more could endanger the life of the woman. Also, some husbands of younger women from Upper Egypt think that such a long period of waiting will deprive fathers from having their children when they are still young. They do not appreciate having children when their hair *"is white"*. Some of the young spacers from Upper Egypt shared the same concern that a man will be less able to provide good care for his children when he is older, and a woman will not have sufficient time to have all her intended children before she reaches the age of 35 years.

Among health providers, some felt that spacing births 5 years apart is too long for women who do not have their first child until age 25 because she will be 35 years old by the time she has her third child. One nurse from Upper Egypt stated that waiting for five years would

make a women feel as if it was her first pregnancy and will experience all the associated problems.

Extremely convincing arguments must be made to convince service providers, married women in the reproductive age as well as husbands, mothers-in-law and mothers that the optimal birth spacing interval is from three to five years.

Recommendations for Achieving Optimal Birth Spacing

In addition to the factors listed above, the two most serious impediments to women achieving their desired *"resting"* period are related to contraceptive use and the practice of *"clean lactation"* as a method of contraception. Though the National Family Planning Program has successfully integrated various methods of contraceptives into their services, side effects, misinformation and provider bias have limited the use of modern methods in Egypt. For example, women who have not been told about the potential side effects, or who cannot tolerate the side effects, of contraception often discontinue use without seeking another method. Also, healthcare providers may prescribe IUDs, injectables or oral pills based upon their beliefs about the effect of each on fertility, their popularity and the likelihood of compliance, and not necessarily based on medical evidence and women's individual situations. More emphasis on contraceptive side effects and advantages and disadvantages of each method should be addressed through counseling visits.

In addition to physicians, television campaigns are also important sources of information on birth spacing and contraception. In order to be effective these television spots must be directed to women and men of all ages, including younger and older married women, husbands and mothers-in-law. With more general awareness of the danger of pregnancies not properly spaced, women will have less responsibility for convincing their families of the benefits the *"resting"* time can have for themselves and their children. Additional sources of information dissemination are contraceptive package inserts and brochures and posters endorsed by the MOH stating that the optimal birth spacing intervals is between three and five years.

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